**PEDIATRIC DERMATOLOGY OF ORANGE COUNTY**
**3500 Barranca Parkway, Suite 160**
**Irvine, CA 92606**
**Ph: 949.336.6569 Fax: 949.336.6570**

# AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

I, _____, the parent / legal guardian,
give Pediatric Dermatology of Orange County authorization to treat my child,
_____, in my absence.
I give _____ my permission to make healthcare decisions for my child.

I understand that I am financially responsible for all charges for services rendered in my absence. I agree to pay all bills for services rendered in my absence.

I would like for this to include:

☐ only the authorization to bring the child to the appointment.

☐ authorization to bring the child to the appointment and authorization to consent to procedures.

☐ This consent is valid only for the following date(s) of service: _____

☐ This consent is valid for one year from the date signed.

_____
Parent / guardian signature

_____
Date

This authorization is given pursuant to the provisions of *Section 25.8* of the Civil Code of California.